REQUEST FOR EMERGENCY SERVICE AUTHORIZATION

This form is intended to be used only for an emergency request for authorization of a service outside usual business hours (i.e., 8:00 a.m. to 4:30 p.m. Monday - Friday) or on holidays, when the service is needed prior to the next business day. The authorization may not exceed an amount that is sufficient until the next business day. Upon approval, this form serves as an amendment to the ISP and must be maintained with the ISP.

Service Recipient _____ **Date of Birth** _____ **SSN** _____

ISC/Case Manager _____ **Provider** _____

For HCBS Waiver Services Only (Please check YES or NO.)

YES NO

[ ] [ ] Is the requested service consistent with the waiver service definition?

[ ] [ ] If the service recipient is under age 21 years, is the service excluded from coverage based on age (e.g., Behavior Services for children)?

Service Name & Type of Request	Provider Name & Provider Code	Start Date & End Date	Unit Rate & Unit Type	# of Units & Cost	Decision	
					Approved	Referred for review
					[ ]	[ ]
					[ ]	[ ]
					[ ]	[ ]

TYPE OF REQUEST: **1. Continue** the Service; **2. Add** as New Service; **3. Delete** the Service; **4. Increase** the Service; **5. Decrease** the Service.

Briefly describe the circumstances justifying the request for emergency authorization _____

_____

_____

Name of AOD _____ **Signature** _____ **Date**_____ **Authorization Code:**

_____

Name of Plans Reviewer _____ **Signature** _____ **Date**_____